IDAHO DEPARTMENT OF
HEALTH & WELFARE

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September 12, 2006

Cynthia Riedel, Administrator
Ivy Court
2200 Ironwood Place
Coeur d'Alene, ID 83814

Provider #: 135053

Dear Ms. Riedel:

On **August 28, 2006**, a Complaint Investigation was conducted at Ivy Court. Marcia Key, R.N. and Lorna Bouse, L.S.W. conducted the complaint investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001587

ALLEGATION #1:

The complainant stated an identified resident was in poor condition when he arrived at the receiving facility. The resident had an infection at his tube feeding site. The site was red and inflamed and purulent fluid was coming from the site. The site was packed with gauze. The resident had a Foley catheter and that site was also infected and bleeding. The drainage bag had brown dark urine. The resident was taken to the facility's physician and was started on an antibiotic for a bladder infection. The resident's toe nails on both feet were so overgrown (curled around to the other side) that he had to be taken to a Podiatrist for treatment. The resident's perineal area was very red and excoriated and had a rash. The resident also had a reddened area on his left foot and a bruised area to the outside of his left forearm.

FINDINGS:

The identified resident's closed record was reviewed. The resident had occasionally pulled out his feeding tube, requiring a hospital visit for another placement of the tube. The resident had pulled the tube out two days before being transferred to the receiving facility. He had been taken to the hospital where the tube was again properly placed. The physician's notes indicated the site looked good without signs of infection.

The resident was ordered to have a Foley catheter placement for his transport to the new facility. The resident did not normally have a Foley catheter placement. Nothing unusual was documented in the nurses' notes regarding the resident's urine or catheter placement. There was no indication of a urinary tract infection while the resident was in the facility.

The resident had thick yellow (fungal infection) of his toe nails upon admission to the facility in June 2005. His physician's orders included that he could be seen by a Podiatrist. The facility did not have a record of a recent Podiatrist visit nor did they have documentation of a description of his toe nails upon discharge from the facility.

According to documentation in the records, which included weekly skin checks, the resident had no red or excoriated perineal area. There was no documentation that he had bruises to his foot or forearm. The facility's incident and accident reports were reviewed. There was no documented evidence the resident had injured himself while in the facility.

The Administrator, Director of Nursing Services, Unit Manager and a Nurse Aide who cared for the resident were interviewed.

The Nurse Aide indicated the resident's nails were in good condition when he left the facility. She stated she had given the resident nail care when he was being discharged.

The Unit Manager Registered Nurse stated the resident had not had an excoriated perineal area while in the facility nor any other skin abrasions or bruises upon discharge. She stated there had been no problems with the Foley catheter when it was inserted and the resident had tolerated the procedure well. In addition, she said his feeding tube site looked good.

The facility did not provide evidence that the resident had been seen by the Podiatrist.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Cynthia Told for

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj